

## Chapter Two

# Millennium Health Goals: paths to the future

The Millennium Development Goals (MDGs) place health at the heart of development and represent commitments by governments throughout the world to do more to reduce poverty and hunger and to tackle ill-health, gender inequality, lack of education, access to clean water and environmental degradation. Three of the eight goals are directly health-related; all of the others have important indirect effects on health. This chapter traces the origins of the MDGs and tracks the progress so far towards achieving them. It warns that without significantly strengthened commitments from both wealthy and developing countries, the goals will not be met globally.



# 2

## Millennium Health Goals: paths to the future

The Millennium Development Goals (MDGs) adopted by the United Nations in 2000 provide an opportunity for concerted action to improve global health. They place health at the heart of development and establish a novel global compact, linking developed and developing countries through clear, reciprocal obligations.

Seizing the opportunity offered by the MDGs will not be easy. Wealthy countries have so far failed to live up to all of their responsibilities under the compact, which include establishing fairer international trade policies, increasing official development assistance, delivering debt relief and accelerating technology transfer. Despite progress in some cases, many developing countries are not currently on track to achieve their health-related MDG objectives. Without significantly strengthened commitments from both developed and developing countries, the MDGs will not be met globally, and outcomes in some of the poorest countries will remain far below the hoped-for achievements. WHO and international health partners must intensify their cooperation with Member States to speed up progress towards the MDGs and ensure that gains are made by those most in need.

### International commitments at the Millennium Summit

In September 2000, representatives from 189 countries, including 147 heads of state, met at the Millennium Summit in New York to adopt the United Nations Millennium Declaration (1). The declaration set out the principles and values that should govern international relations in the 21st century. National leaders made specific commitments in seven areas: peace, security and disarmament; development and poverty eradication; protecting our common environment; human rights, democracy and good governance; protecting the vulnerable; meeting the special needs of Africa; and strengthening the United Nations.

The Road Map (2) prepared following the Summit established goals and targets to be reached by 2015 in each of these seven areas. The goals in the area of development and poverty eradication are now widely referred to as the Millennium Development Goals. They represent commitments by governments worldwide to do more to reduce poverty and hunger and to tackle ill-health, gender inequality, lack of education, lack of access to clean water, and environmental degradation. They also include commitments to reduce debt, increase technology transfers and build development partnerships.

## A compact to end poverty

The idea of the MDGs as a compact, in which both rich and poor countries have responsibilities, was further developed in early 2002 at the International Conference on Financing for Development, in Monterrey, Mexico. The resultant Monterrey Consensus (3) reaffirms the importance of the MDGs and provides a framework for building the partnerships that will be needed to achieve them. A few months later, in September 2002, the World Summit on Sustainable Development, held in Johannesburg, South Africa, took the process a step further by recognizing that poverty reduction and the achievement of the MDGs were central to the overall sustainable development agenda (4). Both the *World development report 2003* and the *Human development report 2003* have further developed the concept of a compact, with a view to informing policy.

The MDGs summarize some of the key commitments made at the major United Nations conferences of the 1990s. They also build on the international development targets prepared by the Organisation for Economic Co-operation and Development (OECD) in 1996 (5). However, it is the two-way nature of the compact that sets the MDGs apart from their predecessors. Developing countries are committed to achieving Goals 1–7. Goal 8 concerns developed countries and the actions that they can take in order to create a more enabling environment in the areas of trade, development assistance, debt, essential medicines and technology transfer. Without progress on Goal 8, it is unlikely that the poorest countries will be able to tackle the structural constraints that keep them in poverty, or sustain the levels of investment required to achieve the other goals.

### New concepts of poverty and development

Since the early 1990s, the concepts of poverty and development have evolved away from an exclusive emphasis on income towards a fuller notion of human well-being, as found in the United Nations Development Programme's Human Development Index (HDI) and other multifactorial indices, which provide alternatives to per capita gross national income (GNI) as a measure of development (6).

In this new understanding, poverty means not just low income but the undermining of a whole range of key human capabilities, including health. The term *human poverty* refers to deprivation of the means to achieve capabilities (for example, physical access to health care) and of basic "conversion" factors that facilitate this achievement (such as social access to health care) (7). *Human development* refers to processes that enlarge people's choices to enable them to achieve capabilities (for example, the freedom to choose a healthy lifestyle) (8).

### The interaction of health and development

This more complex concept of poverty and development takes account of the interactive processes that are crucial to the social dynamics of health improvement. For example, economic capabilities affect health, as low income constrains access to health care and health-promoting opportunities. Equally significantly, ill-health limits people's ability to earn higher incomes, and contributes to poverty.

The two-way causal relationship between economic development and health has been highlighted by the Commission on Macroeconomics and Health, in order to underline the crucial role of health in economic growth (9). The importance of health within a multidimensional model of sustainable human development is also a key message of the MDGs.

Improvements in health are important in their own right, but better health is also a prerequisite and a major contributor to economic growth and social cohesion. Conversely, improvement in people's access to health technology is a good indicator of the success of other development processes. All of these relationships are evident in the MDGs. Thus, three of the eight goals, eight of the 18 targets required to achieve them, and 18 of the 48 indicators of progress are health-related (see Table 2.1).

The MDGs are interrelated and interdependent. In many countries, it will be impossible to achieve a 50% reduction in income poverty (Goal 1, Target 1) without taking steps to ensure a healthier population. Similarly, eliminating gender disparities (Goal 3) and increasing enrolment rates for primary education (Goal 2) are prerequisites for success in improving health outcomes. Population health can no longer be considered in isolation from questions of the stewardship of natural resources and environmental sustainability (Goal 7). It is therefore important that the health-related MDGs are not seen in isolation – as discrete programmes – but as the result, or desired outcome, of a development agenda with several parts working together.

One of the most challenging goals, to achieve a two-thirds reduction in child mortality (Goal 4, Target 5), requires technical interventions that tackle the major causes of child deaths, such as malnutrition, infections and parasitic diseases. But the effectiveness of these interventions will be mediated through a network of public and private delivery systems, and will depend on adequate levels of financing. Their effect will be reinforced by actions such as those that ensure greater food security and access to education, essential medicines and clean water, and by improved public expenditure management. The ability of governments to finance these efforts will be influenced by both the domestic and international policy and trade environments, and, in poorer countries, by the availability of external financial assistance. The MDGs are consequently a way of assessing and tracking progress in development on a number of critical fronts. They are a shorthand for the *ends*, or outcomes, that governments have committed themselves to achieving, rather than a prescription for the *means* by which those ends are to be achieved.

## Progress and prospects

Despite political consensus and the avowed commitment of countries throughout the world, the MDGs will not be achieved at current rates of progress.

The *Human development report 2003* notes that “if global progress continues at the same pace as in the 1990s, only the Millennium Development Goals of halving income poverty and halving the proportion of people without access to safe water stand a realistic chance of being met, thanks mainly to China and India. Sub-Saharan Africa would not reach the goals for poverty until the year 2147 and for child mortality until 2165. And for HIV/AIDS and hunger, trends in the region are worsening”. There are some areas where optimism is justified, but the general outlook, in particular for sub-Saharan Africa, is bleak. Even in countries that are making overall progress, gaps in health status between rich and poor may be widening (see Box 2.1).

It is generally agreed that **reducing child mortality** by two-thirds before 2015 is the furthest of all the health-related goals from being realized. Infant and child mortality is the most complex development indicator, as it is considered to include systemic as well as socio-economic and cultural factors (see Box 2.2). Overall, the Caribbean, central Asia, Europe, Latin America, some countries of the Eastern Mediterranean Region and northern Africa may be

**Table 2.1 Health-related Millennium Development Goals, targets and indicators****Goal: 1. Eradicate extreme poverty and hunger**

**Target:** 2. Halve, between 1990 and 2015, the proportion of people who suffer from hunger

**Indicator:** 4. Prevalence of underweight children under five years of age  
5. Proportion of population below minimum level of dietary energy consumption<sup>a</sup>

**Goal: 4. Reduce child mortality**

**Target:** 5. Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

**Indicator:** 13. Under-five mortality rate  
14. Infant mortality rate  
15. Proportion of 1-year-old children immunized against measles

**Goal: 5. Improve maternal health**

**Target:** 6. Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

**Indicator:** 16. Maternal mortality ratio  
17. Proportion of births attended by skilled health personnel

**Goal: 6. Combat HIV/AIDS, malaria and other diseases**

**Target:** 7. Have halted by 2015 and begun to reverse the spread of HIV/AIDS

**Indicator:** 18. HIV prevalence among young people aged 15 to 24 years<sup>b</sup>  
19. Condom use rate of the contraceptive prevalence rate  
20. Number of children orphaned by HIV/AIDS

**Target:** 8. Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

**Indicator:** 21. Prevalence and death rates associated with malaria  
22. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures  
23. Prevalence and death rates associated with tuberculosis  
24. Proportion of tuberculosis cases detected and cured under Directly Observed Treatment, Short-course (DOTS)

**Goal: 7. Ensure environmental sustainability**

**Target:** 9. Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources

**Indicator:** 29. Proportion of population using solid fuel

**Target:** 10. Halve by 2015 the proportion of people without sustainable access to safe drinking-water

**Indicator:** 30. Proportion of population with sustainable access to an improved water source, urban and rural

**Target:** 11. By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers

**Indicator:** 31. Proportion of urban population with access to improved sanitation

**Goal: 8. Develop a global partnership for development**

**Target:** 17. In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries

**Indicator:** 46. Proportion of population with access to affordable essential drugs on a sustainable basis

<sup>a</sup> Health-related indicator reported by FAO only.

<sup>b</sup> Indicators from the MDG list reformulated by WHO and United Nations General Assembly Special Session on HIV/AIDS.

more or less on track, but several countries in each region are not. Some countries of the South-East Asia Region are behind schedule and sub-Saharan Africa, as noted above, is not likely to reach the target until the second half of the next century. If overall trends continue, under-five mortality worldwide will be reduced by approximately one-quarter over the period 1990–2015, which is very far from the goal of a two-thirds reduction. Lack of progress can be attributed to mother-to-child HIV transmission in some parts of Africa, but for most countries the problem is long-standing underinvestment. This applies to efforts both to reduce malnutrition and to achieve full coverage of interventions to reduce mortality from diarrhoea, pneumonia, vaccine-preventable diseases, malaria and perinatal causes.

The **maternal mortality** picture shows a similar divide between, on one side, southern Asia and sub-Saharan Africa, and on the other, the rest of the world. There is a hundred-fold difference in lifetime risk of dying in pregnancy between the world’s poorest and richest countries. One of the indicators of progress, the proportion of births attended by skilled personnel, is rising slowly from a very low base in parts of the South-East Asia Region, and stagnating in sub-Saharan Africa. Only a dramatic improvement in the quality and coverage of health services is likely to have a significant influence on progress in relation to this goal (see Box 2.3).

The global HIV/AIDS pandemic continues to worsen, with over 70% of all infections occurring in sub-Saharan Africa. Around 40 million people are now living with AIDS, over 5 million new infections occur each year and, in 2002, almost 3 million people died as a result of the disease. Progress is currently measured (for the purposes of tracking Goal 6) by

**Box 2.1 Progress towards the Millennium Development Goals – the case of Uganda**

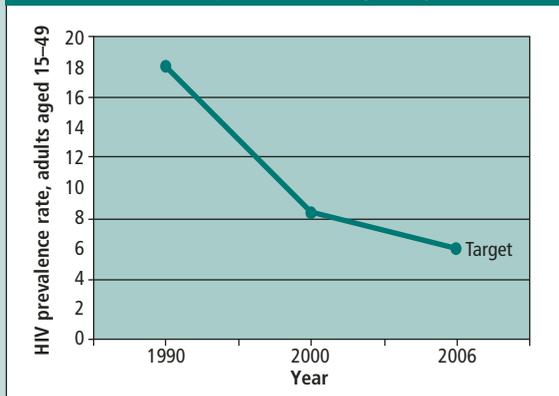
Many sub-Saharan African countries are struggling to make progress towards the Millennium Development Goals (MDGs). Nevertheless, some countries in WHO’s African Region have registered impressive gains (10, 11).

Uganda, for example, cut poverty sharply in the 1990s and will achieve the MDG poverty reduction target if present trends continue. Specifically pro-poor economic policies may be needed, however, in order to distribute the fruits of economic growth more evenly between rich and poor, especially in rural areas. Furthermore, growth itself needs to be revived through economic diversification. In controlling the spread of HIV, Uganda’s progress has actually been more rapid

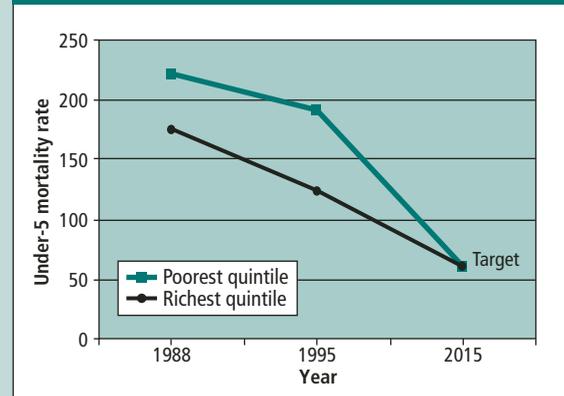
than that required to reach the MDG target (Figure A).

Progress in reducing mortality in children under five years of age has also been substantial. However, it is important to disaggregate the under-5 mortality data in order to understand the impact on different socioeconomic groups. As Figure B indicates, the gap between the richest and poorest sections of the population widened in the mid-1990s. While the richest made gains in line with the MDGs, much less progress was observed for the poorest households. Since the poor make up over a third of Uganda’s population, instituting a “bottom-up” approach that focuses on the needs of the lowest quintiles first could achieve the MDG under-5 mortality target ahead of time.

**Figure A Current and projected progress towards MDG HIV prevalence target, Uganda**



**Figure B Rich and poor – unequal progress towards MDG under-5 mortality targets, Uganda**



### Box 2.2 Child survival – turning knowledge into action

Despite progress in recent decades, globally more than 10 million children still die every year. The number of children and adolescents who died in 2002 was twice the total of adult deaths from AIDS, tuberculosis and malaria combined. All but about 1% of these child deaths occur in developing countries, and more than half are caused by malnutrition, pneumonia, diarrhoea, measles, malaria, and HIV/AIDS. Effective low-cost interventions are available that could prevent at least two-thirds of these deaths. Some interventions are preventive, for example breastfeeding, insecticide-treated materials, complementary feeding, zinc, vitamin A supplements, improved delivery procedures and immunization. Others involve treatment, such as oral rehydration therapy, antibiotics for sepsis and pneumonia, antimalarials and newborn resuscitation. The challenge is to deliver these life-saving interventions to the children who need them most.

Scaling up effective child health interventions will require increased attention to newborn health and the application of an integrated, comprehensive approach to child health at country level.

Although significant progress has been achieved during the past 10 years in reducing mortality in childhood, there has been little progress in reducing deaths among newborns. Almost 4 million infants every year do not survive their first month of life. Most newborn deaths are a consequence of poor health and nutritional status in the mother, absent or low-quality care during pregnancy and delivery, and inadequate basic care of the healthy baby and management of the sick infant. Action to improve the health and survival of newborns and their mothers is urgently needed. High-quality maternity services, including skilled attendants at delivery, can save both newborns and their mothers. Early and exclusive breastfeeding protects newborn lives. A recent

meta-analysis has shown that children in Brazil, Pakistan and the Philippines who were not breastfed were 5.8 times more likely to die by the age of one month than children who received at least some breast milk (12). There should be a skilled attendant at every birth, infection control for the newborn, support for exclusive breastfeeding, and identification of complications. If necessary, the infant should be referred urgently to higher levels of health care.

Child health programmes need to move beyond tackling single diseases and instead deal with the child's overall health and well-being. Based on the experiences of Integrated Management of Childhood Illness (IMCI), WHO, together with partners, is developing a simple but comprehensive framework that will guide countries on implementation and scaling-up of effective child health interventions. The framework has five components:

- A situation analysis to assess variables specific to country or context such as burden of child diseases, socioeconomic status, infrastructure, health system capacity, available resources, political stability and predictability for investments.
- Development and formulation of a concise national child health policy with outcome-oriented strategic directions.
- Identification of a set of proven cost-effective child health interventions.
- Scaling-up of interventions through a two-pronged approach: increasing health system efficiency to serve more children, and engaging families and communities more closely in disease prevention and care for sick children.
- Ongoing monitoring designed to inform decision-making at operational level and support countries and partners in measuring progress.

reductions in HIV prevalence among pregnant women aged 15–24 years (where in some African cities it is beginning to decline), by the number of HIV/AIDS orphans (which is forecast to double by 2010), and by increases in condom use in the 15–24-year age group. Some countries could reach the target of reversing the spread of AIDS by 2015, but again, not without an unprecedented increase in the level of effort in the worst affected regions.

Similar prospects overshadow the other health-related targets and indicators – those related to tuberculosis and malaria, improved water sources, improved sanitation, and solid fuel as an indicator of indoor air pollution. While limited progress has been made in some countries, major differences in achievement exist between and within regions and countries. There are major variations in the provision of essential medicines: WHO estimates that 15% of the world's population consumes 91% of the world's production of pharmaceuticals (by value). Overall progress depends on what happens in the world's largest countries, such as China and India. Above all, success in achieving the health-related MDGs requires much more commitment and effort between now and 2015 than has been evident since the countdown started in 1990.

## The other side of the compact: Goal 8

Most discussion of the MDGs focuses on Goals 1–7. However, a comprehensive assessment of progress requires an examination of both sides of the compact. Defining indicators for Goal 8 has been difficult. Indeed, there has been a reluctance on the part of some developed

### Box 2.3 Fighting maternal mortality – making pregnancy safer

For more than 30 million women each year, pregnancy and childbirth mean unnecessary suffering, ill-health or death. More than half a million women die annually of pregnancy-related complications, 99% of them in developing countries. Yet most maternal deaths and disabilities could be avoided through better-quality health services and good maternal nutrition.

Of all health statistics, those for maternal mortality represent some of the greatest disparities between developing and developed countries. The lifetime risk of dying from maternal causes in sub-Saharan Africa is 1 in 16, compared with 1 in 160 in Latin America and 1 in 4000 in western Europe. In poor countries, as many as 30% of deaths among women of reproductive age (15–49 years) may be caused by pregnancy-related causes, compared with a rate of less than 1% in Australia, Europe, Japan, New Zealand and North America.

Each maternal death is a tragedy. Every year, millions of children are left motherless and an estimated one million children die as a result of the death of their mother. Babies who survive their mother's death seldom reach their first birthday. The risk of death for children under five years of age is doubled if their mother dies in childbirth.

Although the causes of high maternal and perinatal morbidity and ways of preventing and treating them are well known, progress in many countries remains slow. However, some countries – including very poor ones – have been successful in reducing maternal mortality. Maternal and newborn deaths can be significantly reduced by the use of evidence-based maternal health interventions that are reliable, cost-effective and

feasible, even in poor settings.

Through its Making Pregnancy Safer initiative, WHO works with countries to achieve their Safe Motherhood goals. The fundamental idea of the initiative is to increase the proportion of pregnancies and births attended by skilled health personnel. For national policy-makers, the most important issues for improving maternal health are:

- Promoting legal reform and community mobilization to enable women to have access to proper care during pregnancy, childbirth and the postpartum period.
- Developing and implementing plans to train and deploy sufficient numbers of skilled health workers, providing them with essential supplies and equipment, and ensuring that they are present in poor and rural communities.
- Ensuring that all women and their newborn babies have access to quality skilled care, including antenatal care; birth care; obstetric emergency care; postpartum care; newborn care; management of abortion complications and post-abortion care; family planning services; adolescent reproductive health education and services; and also safe abortion care, where abortion is legal.
- Ensuring that the coverage and use of maternal health services are monitored, and the findings used to strengthen future activities and improve the quality of care.
- Strengthening research networks and dissemination of critical findings to improve planning and decision-making regarding critical interventions.

countries to endorse the MDGs because of the very existence of Goal 8. Moreover, the commitment by OECD countries to transfer to low-income countries 0.7% of their annual GNP as a contribution to development assistance (agreed since the early 1970s) has been met by only a very few. The average development assistance transfer for OECD countries, as a percentage of GNP, is still extremely low.

Three aspects of the partnership for development are seen by most countries as being particularly important and offering the chance of progress: the World Trade Organization (WTO) round of trade talks at Doha, Qatar, in 2001 (although the September 2003 ministerial conference discussions in Cancun, Mexico, must also be considered), the Monterrey Consensus on development financing, and the Highly Indebted Poor Country (HIPC) Initiative on debt relief. Their importance has both substantive and symbolic elements: substantive because of the influence of trade, debt and development assistance on national economies; and symbolic because of the need to build trust in an increasingly polarized debate between developed and developing countries around roles and responsibilities for development.

## Trade

Five issues continue to dominate the trade and development agenda: the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement and public health; trade in health services; tariffs and subsidies for agriculture and market access for non-agricultural products; aligning special and differential treatment with national development priorities; and capacity strengthening in least developed countries. The first two issues have an obvious and direct impact on health. The others are equally important, in the light of their impact on the economies of the developing world.

Following the ground-breaking Doha Declaration on the TRIPS Agreement and Public Health in 2001, WTO members reached consensus in August 2003 on implementation of the issue of access to medicines by countries with little or insufficient capacity for pharmaceutical production. The full impact of the agreement will depend on how effectively it can be implemented in countries.

### Development assistance

Achievement of the MDGs is unlikely in the absence of a significant increase in development assistance. The most commonly quoted overall figure is an annual increase of US\$ 50 billion, roughly double current levels (3). The Commission on Macroeconomics and Health estimate of the requirements for investments, primarily in the health sector, was a total annual figure for development aid of US\$ 27 billion – implying at least a four-fold increase in current donor spending on health. Given these estimates, the response has generally been modest, and only a few donor countries have made significant progress towards the 0.7% GNP target. Despite overall trends, however, spending on health and combatting AIDS has increased. Another significant trend is the move towards innovative financing mechanisms, such as the United States Millennium Challenge Account; the Global Fund to Fight AIDS, Tuberculosis and Malaria; and the International Financial Facility proposed by the Government of the United Kingdom.

### Debt

More than six years after its launch, it is clear that the HIPC Initiative has had only limited results. By March 2003 only seven countries had reached their completion point, granting them a 90% reduction in the net present value of their debt service from official creditors. In some HIPC countries, even the modest gains from debt relief have been offset by falls in export earnings owing to deteriorating terms of trade. While the arguments continue about the advantages and disadvantages of the various approaches to debt relief, it is evident that a large and ongoing debt burden acts as a significant counterweight to development assistance, and is a major constraint to increases in domestic funding for human development. Moreover, out of 82 countries eligible for the Poverty Reduction and Growth Facility/HIPC/Poverty Reduction Strategy Paper process, only seven have been through the entire process during the last seven years, which may jeopardize the effectiveness of the debt relief initiative to reduce poverty rapidly.

In summary, an overview of progress towards Goal 8 – even in the absence of robust indicators – presents a picture similar to that for Goals 1–7. Much greater efforts are required if the global commitments are to be met. Monitoring issues and progress in relation to Goal 8 need to be placed high on the MDG agenda.

## The Millennium Development Goals in practice

While there is little doubt that the MDGs represent an important opportunity for promoting improved health outcomes for poor people, they are the product of a political process and are an imperfect instrument. Several questions and issues have arisen from the practical experience of using the MDGs. Some represent areas in which improvements should be made in the future.

## Who owns the MDGs?

National ownership is an important issue. The power and purpose of the MDGs is that they represent a means by which people can hold authorities accountable (for this reason, accessible reports in local languages are a key part of the United Nations strategy). There is a risk, however, that the MDGs are seen by some developing countries as being of primary concern to donors; they may be perceived to be a new form of conditionality and too restrictive in their scope to cover the multifaceted nature of development. The second concern also encompasses the fear that an exclusive focus on the MDGs indicates a rejection of the goals of other United Nations conferences (see the discussion on reproductive health below). Maintaining a genuine political consensus in the face of these fears is a critically important challenge.

## How flexible is the approach?

Many countries argue that the targets should be adapted more closely to their level of development, questioning the point of striving towards a goal that has little chance of being achieved. Other countries recognize the value of targets, but want to make them more ambitious or broaden their scope (sometimes referred to as MDG Plus). Some countries argue that it is inappropriate in many parts of the world to concentrate on communicable diseases, given the rapid increases in the effects of noncommunicable diseases, tobacco-caused illness and injuries on the health of poor populations (see Box 2.4). The current health-related goals, targets and indicators of the MDGs only partially reflect the rapid transition of the disease burden in developing countries. There is an increasing call for a set of regional and global goals with timed targets for noncommunicable diseases and their risk factors, neuropsychiatric disorders and injuries.

Clearly there is a need to strike a balance between the need for comparability between countries and the need to ensure relevance (and ownership). If standardized indicators are used, there is no reason, in principle, why countries should not be able to report on their own as well as international targets; as with the MDGs, timed noncommunicable disease targets and practical policies would require focus and commitment by the international health community. WHO will push for a more ambitious and more complete set of global health goals and targets.

### Box 2.4 Millennium Development Goals in eastern Europe

Eastern Europe is not usually the main focus of the debate about development in general and the Millennium Development Goals (MDGs) in particular, although a number of eastern European countries now have per capita incomes comparable to those in developing countries in the African and South-East Asia Regions. Much of today's low level of economic development is the result of the substantial drop in output during the decade following the transition to market economies.

Strong national and international commitment is required if eastern Europe is to reach the poverty reduction goal by 2015. Whether this can be achieved depends, among other things, on the degree to which progress towards the other MDGs is achieved and on whether the

selected indicators for the other goals match the priority areas for Eastern Europe. There is some evidence to suggest that the latter may not be the case in regard to health-related indicators (13).

In the developing countries of sub-Saharan Africa and the South-East Asia Region the key health problems revolve around issues of child and maternal health as well as infectious diseases, but this is not the case in most eastern European countries, where relatively high adult mortality and noncommunicable diseases account for the largest burden of disease. In the special case of eastern Europe, the use of additional health indicators (such as life expectancy) would therefore be useful.

## How pro-equity are the MDGs?

The most serious criticism is that the health-related goals, unlike many of the other MDGs, are expressed in terms of national averages rather than gains among poor or disadvantaged groups. Significant progress in non-poor groups can result in the achievement of goals with only minor improvements in the health status of the poorest (14). The questions then arise: how pro-equity is any progress towards the MDGs? How do lower income groups benefit relative to higher income groups? Different policy choices within the MDG agenda can produce very different social distributions of health benefits. Efforts to reduce under-five mortality in Latin America in the 1990s, for example, distributed gains very differently to the poorest and richest population quintiles in various countries. Guatemala's pro-equity policies led to the greatest decreases in child mortality occurring among the country's poorest people. Other countries, however, saw the under-five mortality situation of the poorest families worsen relative to outcomes among the richest, even as aggregate national averages improved (11). Thus the capacity to disaggregate health data by criteria such as income level becomes crucial to informed policy-making. This requirement must be taken into account in the design of health information systems at country level.

## Measuring progress

Although the MDGs and targets were agreed during the political process that forged the Millennium Declaration, the associated indicators were decided on after the event. Many people regard the indicators for the health targets as unsatisfactory. Some indicators include more than one entity to be measured; some are not disaggregated for the population affected by, or vulnerable to, the targeted disease; some are costly to collect; and others have poorly defined numerators or denominators. Some improvement has been made possible by the inclusion of additional indicators, for example on overall healthy life expectancy, to complement disease-specific mortality, but these additions still have only the status of footnotes. There is a reluctance to open up the process to change – at least until a fundamental review has taken place in 2005.

## Reproductive health

The International Development Goals that preceded the MDGs made explicit reference to the provision of reproductive health services, based on goals and targets agreed at the International Conference on Population and Development, held in Cairo, Egypt, in 1994 (15). These are not included in the MDGs. Their absence concerns many who fear that the gains achieved in Cairo and at the five-year follow-up (ICPD+5) may be lost. In practice, several key dimensions of reproductive health feature in the MDGs – such as maternal health, child health (including health of the newborn) and HIV/AIDS. Within WHO, in response to a resolution of the World Health Assembly (16), a strategy for accelerating progress towards the attainment of international development goals and targets related to reproductive health is currently being prepared.

## Health systems strengthening

The MDGs do not specifically deal with health systems strengthening, and this fact has drawn criticism. It is clear that in many low-income and middle-income countries the health-related MDG targets will not be attained – or, more importantly, sustained – in the absence of significant strengthening of their health systems. Yet the goals highlight core, long-term health

issues for countries, and some of the indicators, on maternal mortality for example, can serve as proxy markers for the efficacy of the health care system as a whole. The MDG concept requires simultaneous progress on a broad front. There is clearly little chance of making simultaneous significant gains in child and maternal health, HIV/AIDS, tuberculosis and malaria, and better access to the right drugs, without adequate investment in health systems.

A concerted effort to tackle health systems constraints on a scale commensurate with the extent of the problem is central to achieving the MDGs and other health goals. The key issues to be confronted are discussed in Chapter 7.

Concurrently, cross-cutting issues that are not directly connected to health care reform are significant for health-related outcomes. These issues include water and sanitation, transport, and the relationship between several of the MDGs and human rights. This relationship – particularly in respect of the poor – has recently received attention from the United Nations Special Rapporteur on the Right to Health (17).

## The MDGs and WHO

### Defining the place of the MDGs in WHO

The MDGs are assuming increasing strategic importance for many international organizations. For governments and development agencies they provide a focus and a way of both reorienting work and defining parameters for accountability. WHO places great emphasis on support to countries and development partners in their efforts to achieve the health-related MDGs. Some progress has been made, for example, in improving access to essential medicines in countries in each of the six WHO regions (see Box 2.5).

However, this focus on the MDGs does not preclude work on topics or in countries that do not have a direct link to the goals, nor is work on the MDGs confined to those activities of the Organization (such as child health or HIV/AIDS) that are specifically mentioned in one or more goal or target. In this sense, much of the remainder of this report relates to the MDGs. The concept of MDGs represents outcomes, achieved through a wide variety of health actions. But, as has been said about policy development: if it is everything, then it risks being nothing.

#### Box 2.5 Assuring quality of drugs for HIV/AIDS, tuberculosis and malaria

Before 2001, the United Nations and other procurement agencies lacked a coordinated quality assessment system for HIV/AIDS drugs. As efforts accelerate to scale up access to treatment for people living with HIV/AIDS, and as less expensive generic medicines for low-income countries become more easily available, an agreed process for ensuring that these medicines are of acceptable quality will become the basis for increasing procurement volumes (18).

A pilot system was started by WHO in collaboration with other United Nations organizations (UNICEF, UNFPA and UNAIDS) in March 2001 to assess the compliance of HIV/AIDS drugs with international standards, and thus their suitability for procurement by United Nations agencies. The process involved:

- evaluating product information supplied by manufacturers;
- inspecting manufacturing sites;

- conducting random follow-up quality checks of previously assessed products.

More than 250 product dossiers from different innovator and generic manufacturers have been assessed: an increasing number now meet the norms and standards required by WHO. These changes are reflected in the most recent edition of the list of prequalified products and manufacturers, published and regularly updated on the WHO web site (<http://www.who.int/medicines/organization/qsm/activities/pilotproc/pilotprocmain.shtml>). This list now includes 50 antiretrovirals (including 22 generics), comprising 44 monocomponent products, 5 double combinations and 1 triple combination. The initiative has also started on prequalification of malaria and tuberculosis medicines and is making considerable progress.

Three principles will guide WHO's work in relation to the MDGs. First, WHO will work with countries to help them develop and work towards a more complete set of health goals that are relevant to their particular circumstances. Second, WHO will give special priority to helping countries develop goals and plans to ensure that deprived groups share fully in progress towards the health-related MDGs (by, for example, ensuring that the percentage improvement in conditions among people below a country's poverty line is at least as large as the percentage improvement in the national average). Third, at the global level, WHO will vigorously advocate that developed countries live up to their part of the compact, especially by acting on those elements of Goal 8 that are of central importance to the MDGs.

In practical terms, WHO will carry out this work as follows:

- **Normative and technical work.** WHO supports national efforts to achieve the MDGs through an extensive body of normative and technical work in the areas of maternal health, child health, HIV/AIDS, tuberculosis, malaria, water and sanitation, access to medicines, health systems, and environmental health, as well as work on health-related developmental issues such as trade, debt, development assistance and human rights. While all of these areas are important, the challenge of making more rapid progress in child and maternal health means that these objectives demand increasing attention.
- **Tracking progress and measuring achievements.** WHO has worked closely with other organizations of the United Nations system to identify indicators associated with each health-related MDG and target. There has also been significant progress in establishing complementary and coherent reporting procedures. The United Nations Development Programme, the United Nations Population Division and the World Bank are using the databases of UNAIDS, the United Nations Children's Fund and WHO as their main sources of health information in relation to the goals. WHO's work on MDG reporting complements other efforts to improve the quality of country health data. It also aims to build capacity in countries to collect, analyse and, most critically, act on information collected. A framework to improve the quality of health statistics has been developed on the basis of five criteria: validity, reliability, cross-population comparability, data audit traceability, and consultation with national authorities. The sources, methods and full development cycle of any published figures have been made more transparent, and explicit data audit trails are now publicly available and open to peer review.

WHO will report on 17 of the health-related MDG indicators. WHO also monitors core health indicators, as well as indicators for other areas of public health that help explain progress (or lack of it) in the achievement of specific goals at country level. These include immunization coverage for new antigens, prevalence of risk factors for noncommunicable diseases, effectiveness of interventions against these diseases, and impoverishment of households through health payments. WHO is working with partners to develop the Health Metrics Network, which will help strengthen health information systems and thus support the monitoring of MDG indicators (see Chapter 7).

- **Strengthening technical collaboration.** Support in this area will come from all parts of WHO and will be articulated in individual country cooperation strategies. Strengthening WHO's presence in countries is a major priority for the years ahead, and collaboration with countries on meeting MDG targets will be a central thrust of WHO's commitment to help bring measurable health improvements on the ground.

## Working with others

WHO is an active supporter of the United Nations core strategy for achieving the MDGs. This strategy has four components: the independent Millennium Project, operational support by the United Nations country teams at country level, millennium reporting, and the Millennium Campaign.

The **Millennium Project** conducts research on, and analysis of, the strategies needed to achieve the MDGs. Over a period of three years, its 10 task forces will work on the operational priorities, organizational means of implementation, and financing necessary to reach the goals. Preliminary work produced by the project has been used in preparing the *Human development report 2003*. A key role of the Millennium Project, as for the Commission on Macroeconomics and Health, will be generating a clear set of messages and making them available to a political audience which may otherwise be unfamiliar with development issues. Recent interaction with project managers suggests that an additional task force should focus on health systems development issues.

**Operational support** for achieving the MDGs is provided by United Nations country teams. The MDGs have now become an integral part of the instruments – notably the Common Country Assessment and the United Nations Development Assistance Framework – used by United Nations agencies for planning and programming their work. In addition, WHO contributes to the preparation of **national MDG reports** and will work with national authorities to act on their recommendations. Intended for a general audience, the public and local media, the reports focus on progress and constraints and are seen as a means of increasing government accountability. More than 40 have been published so far.

The **Millennium Campaign** aims to raise public awareness of, and political commitment to, the MDGs in both developed and developing countries.

Recognizing the need to keep the health-related MDGs high on the political agenda, the creation of the High-Level Forum on Health, Nutrition and Population Related MDGs has been proposed. The Forum will act as an umbrella body, taking an interest in a wide range of activities that contribute to the achievement of the MDGs. It will provide a structured opportunity for senior officials from donor agencies and national governments to review progress over the whole range of health-related MDGs (but will not itself have any responsibility for monitoring). It will promote lesson learning across countries and regions; it will seek to create links and interaction – particularly between global health partnerships and national poverty reduction strategies; and it will identify opportunities and make recommendations for actions to be taken by others.

## Accelerating progress

The MDGs represent a worldwide commitment to reduce poverty and hunger and to tackle ill-health, gender inequality, lack of education, access to clean water and essential medicines, and environmental degradation. Improvements in health are important in their own right as development goals, and are also seen as major contributors to economic growth and poverty reduction.

The MDGs stand apart from previous sets of international development policy objectives. First, they are explicitly interdependent and interrelated: success in achieving one is dependent on efforts to achieve the others. Second, the targets set out under the first seven goals are

one side of a development partnership. Achievements by developing countries depend on enabling actions by the developed world – in trade, development assistance, debt relief and technology transfer – to complete the other half of the compact. These actions are included in Goal 8.

Despite political consensus and commitment, many of the MDGs will not be achieved unless there is a major increase in effort by all stakeholders. Halfway between the base year of 1990 and the target date of 2015, current rates of progress suggest that in sub-Saharan Africa the goal of reducing childhood mortality by two-thirds, for example, will not be reached this century, let alone in the next 12 years. Moreover, even among countries making substantial progress toward the MDGs, aggregate national gains can be deceptive. It is increasingly evident that significant progress in non-poor groups can result in the achievement of goals with only minor changes in the health status of the poorest.

The MDGs are a means by which people can hold authorities accountable. This will be possible, however, only if the goals are accepted as legitimate, and are owned, by all concerned. Developed countries must fulfil their side of the MDG compact, showing that the MDGs are not a control mechanism imposed by donors, but the start of a new international collaboration to foster, more equitably, essential human capabilities.

This chapter and subsequent parts of this report show that there is much that can be done to accelerate progress. It is possible to scale up efforts to confront the AIDS pandemic, to reduce the risk of death in childbirth, to ensure the survival of children and to strengthen the health infrastructure needed for gains toward the MDGs and other health objectives.

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Chapter 1 confirmed HIV/AIDS as the leading cause of death among young adults. This chapter has shown how important a part it plays in the MDGs. The next chapter describes how HIV/AIDS has changed the world – sub-Saharan Africa in particular – during the last 20 years, why it now represents a global health emergency, and how it can be brought under control.

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